13 March 2018

The Honourable D Clark, M.P.,
The Minister of Health

Dear Minister,

The Division of Medicine comprises 13 different departments. The Heads of Department have summarised some of their main concerns and challenges to give you a broad overview of the issues we face in trying to provide high quality healthcare to our population.

Palliative Care
The hospital palliative care team has been through a number of changes in the last few years in an attempt to cope with the rising numbers of patients. The patients are increasing both in numbers, to a total of nearly 1279 in a 12 month period, and in complexity which is becoming unstainable for the SMO staffing level of 1.3 FTE (Full Time Equivalent). The team is struggling to help deliver good palliative and end of life care to patients as the whole system is overwhelmed. There is great anxiety around what will be the outcome of the End of Life Choice Bill and the impact it will have on the healthcare system.

Haematology
Facilities: For our inpatient service there are on-going difficulties with finding sufficient side rooms for inpatients requiring chemotherapy. We have had multiple occasions recently when a room is not available for patients coming in for planned chemotherapy, leading to delays in the commencement of treatment and subsequent prolongation of their inpatient stay. The problem is exacerbated by the high numbers of General Medicine outliers causing the ward to be constantly full.
Inadequate nursing and medical staff for the safe delivery of chemotherapy in the haematology day ward. Patients should be reviewed from a medical perspective prior to each cycle of chemotherapy, but we do not have the clinic capacity for this to occur. The appointment of a 3rd haematology registrar, and (hopefully) a 7th haematologist will go a large way towards rectifying this problem from a medical perspective. The haematology day ward is staffed at skeleton levels from a nursing and administrative perspective and in the last 4 weeks has been severely short staffed due to previously allocated annual leave and unexpected sick leave. To a large extent we are victims of our own success, keeping many patients alive for longer, and offering them, where appropriate multiple lines of salvage treatment – this has resulted in a burgeoning total patient population and follow-up clinic requirement.
An urgent requirement to promote and develop appropriate training in haematology for nurses within Counties Manukau – we are a speciality which is very reliant on skilled nurses who can recognise and appropriately treat patients with bone marrow failure and severe neutropenia. We have a small pool of nurses with appropriate expertise, and need to grow and maintain this.

Cardiology
Cardio-vascular disease (CVD) is the leading cause of death amongst the Counties Manukau population, especially non-European males, and is linked to high deprivation. The MOH monitor improvement rates in CVD; Counties Manukau Health leads regionally in drug therapy but does not achieve cardiac related intervention rates. CMH is the only large DHB with a single Cardiac Catheter Laboratory and this is a major point of constraint for treating our acute and elective cardiac patients. The $7m capital request for building and equipping a second Cardiac Catheter Laboratory is supported by regional clinicians and decision making forums; however, the cost is currently unaffordable. There is little regional spare capacity and the highly

deprived population of Counties Manukau is receiving inequitable access to life saving/life improving therapies compared with most other areas of NZ (except Northland).
A précis of a patient feedback form received 5th March 2018:
"….I was told to go to Middlemore straight away and I was to have a pacemaker fitted. They felt they couldn't let it go much later…..hoping for Op on Friday….sorry full up Friday, hopefully Tuesday. Heard today no, not Tuesday, hopefully Friday. So disappointed….Please do not have let another patient go through what I have been through these last few days. My care has been first class but that does not get my pacemaker put in."

Gastroenterology
With the pending start of bowel screening in New Zealand, Gastroenterology is finally moving to a prevention ethos many years behind other developed countries. We as clinicians 100% support this long overdue initiative however I still have estimable concerns for the welfare of our population. We need a significant increase in resource for both theatre capacity and manpower that are not adequately funded by the program. Our other work has fallen down with this focus on bowel screening. Nearly every week I see or hear about someone where the 162 day wait for a Gastroscopy that has been clinically assessed should be done in 42 days, has led to a cancer being discovered too late. Those with financial means or private insurance pay for the procedure and those more financially disadvantaged suffer. We are discriminating against our most needy citizens. Please consider some extra funding to ensure that our patients who are not in the screening cohort also get timely and equitable treatment.

Infectious Diseases
High levels of occupancy and demand on staffing severely compromise our ability to limit the spread of infections within the hospital, including those caused by extremely drug-resistant bacteria (as seen in the recent outbreak of carbapenem-resistant organisms in the National Burns service) and epidemic viruses such as influenza.

Rheumatology
The Rheumatology service is struggling to cope with demand because of population growth, increased life expectancy of rheumatology patients from advanced treatments and increasing complexity of patients presenting to the service. While we see the FSA patients within the 4 month time frame, the priority 1 and 2 patients often exceed the allocated waiting times and our follow up patients often need to wait longer for their appointments. At any one time, we have around 500 patients who have expired planned appointments, some of who end up in hospitals as inpatients or their disease has progressed.
Teaching, Trainee supervision and professional development of existing staff suffers because of excessive workload, especially when one member of staff is away on leave. We need more rheumatology FTE.

Dermatology
The current FTE of Dermatologist to population ratio at CMDHB is approximately 1:215,000. However, an international norm would be 1:80,000 – 100,000. CMDHB dermatology rejects hundreds of referrals each year due to inadequate resourcing. This is a significant risk for the patient.
The only way to prevent a waiting list breech and a subsequent MoH fine is to limit access to the service.
Ministry of Health waiting times for First Specialist Appointments give no regard to the ability to provide a dermatology service.
Approximately 20-30% of responses to referrals are virtual and based on the general practitioner's letter and photographs. Whilst in some cases this is an effective use of this service, for many patients it is a less than ideal proxy mechanism to manage demand without seeing the patient physically with concurrent risk to the patient.
Good news….CMDHB have created the first ever Dermatology/Infectious Disease Clinical Nurse Specialist role to liaise between the hospital and community in an attempt to reduce admissions to Middlemore hospital for cellulitis but at 0.5 FTE only this is insufficient resource.

Respiratory Medicine

Outpatients - We have inadequate medical staffing to see FSAs and follow-ups in a timely fashion, leading to unacceptable risk. There is a lack of physical space to run more outpatient clinics even if more staff became available to do these. Clinics remote to the lung function service at Manukau Super Clinic (MSC) create huge inefficiencies.

Increasing demand for sleep-apnoea assessment and treatment - due to a combination of increasing obesity in the community and increased pickup of previously unrecognised symptoms in the community. Even with a number of innovative approaches we are struggling to deal with this demand.

Lung cancer - The ministry target has eaten up large amounts of medical time for meetings and pathway management. SMOs are straining under this burden. Benefits of the target system to patients are unclear. Doctors feel they are being asked to treat the target rather than the patients.

Bronchoscopy - There is an unmet need for more Bronchoscopy; limited by lack of appropriate procedure space. Outpatients for this procedure are frequently rescheduled, inpatient procedures deferred, and wait-times are unreasonable as the system struggles to cope. Two lists per week (our current resource) are grossly inadequate relative to our population.

Inpatients - Inadequate medical beds lead to Respiratory (and other medical) patients being outliers on inappropriate wards leading to inefficiency and risk.

Respiratory Medicine needs to develop a specific Respiratory Registrar out of hour's roster for both service and training reasons; current RMO staffing does not allow for this and the situation is likely to get worse when Schedule 10 rosters are imposed.

Inadequate RMO resource to help the duty SMO look after Respiratory Inpatients on weekends is a major cause of concern and stress to SMOs.

General Medicine

General Medicine is currently in crisis. As a Department our bed demand is exceeding capacity on a daily basis at a time of year where we would expect this not to be so. This does not bode well for the winter this year especially as we expect a flu season on a par with that of 2014/15 where admissions due to flu spiked. We spent much of last winter with an occupancy rate of >100% and at times up to 170%. In reality this means that on some days up to 70 medical patients were being cared for in non-medical beds e.g. surgical, orthopaedic or gynaecology and at times paediatric beds. This is not safe practice and compromises patient care. Mortality rates and length of stay increase as occupancy rates increase and this does not take into consideration the additional stress on all staff. We desperately need an additional 109 beds to cope with this winter alone along with the resource to manage these beds. This does not account for growth as the population of CMH catchment area rapidly increases. We have just been given the go ahead to open an additional 50 beds but will struggle to staff them rapidly and therefore get them open in a timely way for this winter.

We see this year's expansion as phase 1 of what is needed as part of a much larger expansion of medical beds in the coming 2-3 years in order just to maintain a safe environment for our patients and staff. Therefore what is urgently required at CMH is a large building project to house these wards so that medicine can move out of all the other departments it is currently occupying as a cuckoo and the entire hospital will become more efficient.

Renal Medicine

CMDHB renal service is the largest and best dialysis provider in New Zealand. Innovative practices within transplant and home therapies promotion have resulted in stable numbers of facility dialysis patients for the last 4 years (a period of significant national growth). Our critical issues relate to physical infrastructure. The Scott Dialysis Unit at the Middlemore site is not fit for purpose and is a source of cross-contamination of multi-resistant nosocomial infection affecting the entire hospital. All contingencies and mitigation have failed to solve this problem. Unfortunately the renovation required has been linked with the proposed development of a second cardiac catheter laboratory on the floor above the dialysis unit. This has led to several years of delay to the urgently required renovation. We are waiting for final Treasury approval, we believe, in August. Our second infrastructure issue is our home therapies unit, which is run out of a very old and run down facility (that was never intended for clinical use) located in Western Campus. This was

labelled as the least clinically appropriate building in the Auckland region by Geraint Martin some years ago, and a replacement facility was included in the CMH long-term investment plan. Unfortunately this now seems to be many years away.

Diabetes & Endocrinology

The Counties Manukau population is a historically underserved, mobile, rapidly growing and high deprivation population. Like all specialty groups Endocrinology is seeing the disclosure of increasing rates of our common and less common conditions (particularly thyroid disease) as increased and improved access to care, diagnostics, scanning etc. is performed. Growth of population (itself underestimated) funding trajectories and service sizing has underestimated that, and increasingly breaches on times to FSA and follow-up will occur. This is despite our and primary care clinicians efforts with health pathways, virtual reviews, outreach integration etc.

Diabetes is a special case. It has been identified as a health priority for decades in NZ, and here and abroad the growth of the population with diabetes, at younger and younger ages is epidemic. So are the costs and resources to "service" it. It is a significant factor in the existing health inequalities in NZ. Counties are in the worst position nationally as borne out by repeated national statistics (Virtual Diabetes Register, Health surveys etc.). It is occurring at rates increasing more rapidly than population growth, at younger age (more aggressive, longer need for care, more complications), and people living with complications still die on average a decade younger but will consume increased health utilities and with significant morbidity. The size of the problem to manage and palliate complications is also growing at greater than population growth. The growth is unsustainable and unaffordable for the health sector. In Counties we have spent more time, energy and dollars on discretionary activities to "proactively manage" diabetes in community settings than elsewhere. But we are where we are, and we cannot point to population wide return on investment for doing so. We treat with the smallest evidence-based therapeutic armamentarium of all OECD countries, limiting us to a smaller range of treatments with generally greater side effect profile that seems to matter to our patients and primary care prescribers based on the inertia we see. Despite this we provide expensive, state of the art palliation to save vision, limbs, and myocardium and replace the defective kidneys of these people at considerable cost and often unnecessary and preventable morbidity and harm for our patients. They may be relieved to know that we have such therapeutic "ambulances at the bottom of the cliff" as Avastin injections, coronary stenting and the largest dialysis service in Australasia, but if fully informed the 9000 people with abysmal glucose control, and in particular the 2,500 with abysmal control and evidence of diabetic kidney disease who will all need dialysis in 5-10 years unless they die first, must wonder why early detection and definitive workup of cancer is so important (targeted by clinical action) when the evidence-based prevention of such serious complications by improved cardio-metabolic control is just a counting exercise and "trusting" that the right things are being done. Treatment gaps are yawning, clinical inertia is immense. While specialist teams managing the complications of diabetes are growing (but are stretched themselves) to meet the complications of diabetes, specialist diabetes teams (working with people and their diabetes) have not grown with the size of the known diabetes population let alone the increasing complexity. Of course for the population with type 2 DM and those at risk (particularly poor, Pacifica, Maori, Indo-Asian) prevention is the key opportunity for Health. But all the talk about prevention, the little initiatives here and there, the excellent sound clinical advice offered by Drs, nurses, dietitians, health coaches etc. is sadly of little benefit when the environment is so toxic for good healthy living. This is the key challenge. Stop paying health sector people to record the epidemic, put real resource into preventing the disease, and assisting patients to achieve excellent management.

Department of Psychological Medicine

Good health care encompasses mental and emotional as well as physical wellbeing;. Currently the consult liaison psychiatry teams, who see predominantly hospital inpatients with comorbid mental health issues including suicide, people with psychosomatic presentations and adjustment to illness, are not sufficiently staffed to provide full time working day cover, and will need to reduce to 4 day a week cover for adults/older persons and 3 days per week for paediatrics, leaving people with these needs with limited service. Outpatients of many CMH specialist health services are unable to access psychological input to help patients and whanau adjust to illness and improve their functioning and health outcomes.

Adult Rehabilitation and Health of Older People

The Adult Rehabilitation and Health of Older People (65 years and older general population and 55 and older Maori and Pacific patients) division offers specialist services to the older adults, including acute care, and community geriatric services, in addition to rehabilitation. Counties Manukau is home to New Zealand's second largest Maori population, largest population of Pacific peoples, as well as fast growing Asian communities. We have a culturally diverse ageing group, who are living with increasing numbers of long term conditions. In 2017 Counties Manukau had 61,730 older adults, increasing by 4% per year, with 22,000 older adults by 2025. The biggest challenge we face is the increasing numbers of older adults (especially those older than 80 years—anticipated to rise by 50% in next 10 years) with complex comorbidity including significant cognitive problems with dementia, still living in the community and presenting to hospital for management of various illnesses which will impact on all services across the organisation. With the appropriate support we hope to maximise our ability to rise to the challenge of caring for a rapidly ageing population and be part of the organisation wide effort to do so at the right time and place.

Yours sincerely

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Director of Medicine, CMDHB
On behalf of the Heads of Department